CVCB/SAEP/CAC/06/04

***Regional Children's Advocacy Centers***

**CHILD SEXUAL ASSAULT EXAMINATION CERTIFICATE**

Facility Name: _____

Facility Address: _____

Date and Time of Examination: _____

County and State Where Assault Occurred: _____

Date and Time of Assault: _____

PATIENT INFORMATION

Female _____ Male _____

Date of Birth: _____ Age: _____

Social Security Number _____

Patient Number _____

Does the patient have any health insurance coverage (public or private)?

YES _____ NO _____

**PHYSICIAN CERTIFICATION**

I hereby certify that a forensic sexual assault examination/ child sexual abuse examination was performed by me upon the above-named patient on the _____day of _____, 20_____.

_____

Physician (Print Name)

_____

License Number

_____

Signature

**CERTIFICATION OF NOTIFICATION TO LAW ENFORCEMENT**

I hereby certify that _____ with _____

(Name and Title) (Law Enforcement Agency and Telephone Number)

was notified of the above-reported sexual assault on the _____day of _____, 20_____.

_____ _____

(Facility Employee's Signature) (Facility Employee's Printed Name and Title)

**AUTHORIZATION TO RELEASE PATIENT INFORMATION**

I, _____, hereby authorize the facility and physician named above

(Name of Patient or Minor Patient's Parent/Guardian)

to release the Child Sexual Assault Examination Certificate, itemized billing statement(s), and substantiating Physician notes (when requested) for the child sexual abuse examination to the Sexual Assault Examination Program for the purpose of enabling the above-named facility, as well as the examining physician, to present a claim for payment of the forensic examination expenses.

I have received, read and understand a copy of the HIPAA (Health Insurance Portability & Accountability Act of 1966) Notice of Privacy Practices Polices in conjunction with the completion of this form.

_____ _____

(Signature of Patient or Minor Patient's Parent/Guardian) (Date)

**NOTICE TO PATIENT OR PARENT/GUARDIAN:**

You should <u>not</u> receive any billing statements for the forensic services rendered on this date. However, if you do, please contact the Crime Victims Compensation Board at (502) 573-2290 or toll free at 1-800-469-2120.

Send this completed form with itemized billing statement(s) to:

Sexual Assault Examination Program
c/o Crime Victims Compensation Board
130 Brighton Park Blvd.
Frankfort, KY 40601-3417
http://cvcb.ppr.ky.gov

**Billing Questions?**
Contact CVCB at
(502) 573-2290 or
email: CVCB@ky.gov